UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ALOXI (palonostron hcl)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy.
- Must have failed on Zofran, Anzemet or Kytril (5-HT3's).
- No other 5-HT3 medications allowed as rescue drugs

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Repeat course of chemotherapy following initial 6 months requires new authorization